

DEPARTMENT OF SOCIAL SERVICES

744 P Street, Sacramento, CA 95814
(916) 322-3141



March 18, 1982

ALL-COUNTY INFORMATION NOTICE I- 30-82

TO: ALL COUNTY WELFARE DIRECTORS

SUBJECT: UNACCOMPANIED MINOR SEMI-ANNUAL REPORT

REFERENCE:

This letter is to advise all County Welfare Departments that semi-annual progress reports for unaccompanied refugee/entrant minors will be due on March 31, 1982.

The reporting period began September 1, 1981 and ended on February 28, 1982.

A form CA 900 (copy attached) is to be completed for each unaccompanied minor in your county and forwarded to:

Office of Refugee Services
744 P Street, M.S. 4-100
Sacramento, CA 95814

Attention: Sal Barajas

NOTE: For the purpose of identification, please note in the upper right hand corner of the CA 900 whether the report is Final (i.e., the case is being closed) and whether the person is a Refugee or Cuban/Haitian Entrant.

Sincerely,


R. E. REICH
Chief Deputy Director

Attachment

cc: CWDA

REQUEST FOR INFORMATION ON UNACCOMPANIED INDOCHINESE REFUGEE CHILD

NAME (LAST, FIRST, MIDDLE)

SEX

ALIEN NUMBER

SOCIAL SECURITY NUMBER

BIRTHDATE (MONTH, DAY, YEAR)

NAME AND LAST KNOWN ADDRESS OF PARENTS OR RELATIVES

TYPE OF CURRENT PLACEMENT

☐ Foster Family ☐ Group Home ☐ Institution ☐ Supervised Independent Living

NAME AND ADDRESS OF FAMILY OR INSTITUTE WHERE CHILD IS RESIDING (IF SUPERVISED INDEPENDENT LIVING, DESCRIBE)

LEGAL CUSTODY OR GUARDIANSHIP IS HELD BY:

NAME OF SOCIAL AGENCY

ADDRESS

IS CHANGE IN STATUS OF LEGAL CUSTODY OR
GUARDIANSHIP PLANNED?

IF YES, WHAT CHANGE IS PLANNED? WHY?

☐ Yes ☐ No

Briefly describe the child's current functioning in terms of relationship with adults and peers; physical health; emotional well-being; knowledge of English language; and school achievement. (Use back of form if needed.)

Briefly describe the case plan for the child, including short-range and long-range objectives until the time it is anticipated the child will become independent. This should include information about educational and vocational plans. If problems are indicated, briefly describe the services to be provided. (Use back of form if needed.)

NAME OF AGENCY

NAME OF PERSON COMPLETING FORM

DATE